Date Rec'd:_____

School District's Name
Special Education Services
Assistive Technology Team
UAAACT

Initial Referral Form

Student: _____ DOB: ___/___/___ Date: _____
Referral Person: _____ Phone: _____
School: _____ Grade: _____ Track:_____
Parent/Guardian: _____ Phones: _____
Address: _____ City: _____ Zip: _____
Special Education Teacher: _____ Phone: _____
OT: _____ SLP: _____
PT: _____ Vision Specialist: _____
Regular Education Teacher:_____

✶✶✶**Please complete front and back of this form. A copy of the student's current IEP must be included with this referral. Assistive Technology services are based on IEP goals and objectives. Your school's Principal must review and sign this referral before it is sent to the AT Team. Incomplete referrals will be returned. Please return form to UAAACT Team, Jordan Resource Center (565-7584)**

Reason for Referral: Please describe the problems your student is having participating in his educational program. _____
_____
_____

Special Education Eligibility

- ❑ Orthopedic Impairment
- ❑ Deafness
- ❑ Intellectual Disability
- ❑ Multiple Disabilities
- ❑ Communication Disorder
- ❑ Specific Learning Disabilities
- ❑ Autism
- ❑ Developmental Delay (ages 3 through 7)
- ❑ Hearing Impairment
- ❑ Deaf/Blindness
- ❑ Vision Impairment
- ❑ Other Health Impairment
- ❑ Traumatic Brain Injury
- ❑ Emotional Disturbance
- ❑ Behavior Disordered
- ❑ 504 Accommodation

Related Services

Type of Service	Hours Per Week	Name of Provider

Time in Regular Education Class (Hours per week)

Is this student served in a regular education class? ❑Yes ❑No
If yes, specify locations and time: _____
If yes, is teacher or paraprofessional support provided? ❑Yes ❑No

Medical Diagnosis

❑ Down Syndrome
❑ Unknown
❑ Neurological Disease (specify):_____
Other Sydrome: _____

Vision

Date of most recent formal test/screening: _____
Results: _____
Based on formal and informal measures, student exhibits:
❑ no visual impairment
❑ suspected visual impairment
❑ documented visual impairment

Hearingss

Date of most recent formal testing/screening: _____
Results: _____
Based on formal and informal measures, student exhibits:
❑ no hearing loss
❑ suspected hearing loss
❑ mild hearing loss (❑ left ear; ❑ right ear; ❑ both)
❑ Moderate hearing loss (❑ left ear; ❑ right ear; ❑ both)
❑ Severe hearing loss (❑ left ear; ❑ right ear; ❑ both)
❑ Deaf

Specific Information about your student will help us provide better assistive technology services. Please use this checklist to indicate area of concerns.
Student is experiencing difficulty accessing education in the following areas :
❑ Communication
❑ Handwriting (legibility)
❑ Written Expression
❑ Spelling
❑ Reading
❑ Math
❑ Other academic subjects. Describe: _____

_____

_____

❑ Organization (describe): _____

_____

❑ Participating in inclusive setting (describe) : _____

_____

❑ Accessing Print Materials: _____

_____

❑ Access to Educational Materials due to physical handicap.
❑ Toys ❑ Computer ❑ Books ❑ Other (describe):

Principal's Signature: _____ Date: _____